MICHELE CLAEYS DENTISTRY®

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Welcome

Patient Information *(confidential)*

Date _____

Name _____ *Birthday* _____ *Soc. Sec. #* _____

Preferred Name _____ *Home Phone* _____

Address _____ *City* _____ *State* _____ *Zip* _____

Cell Phone _____ *Pager* _____ *Email* _____

Check Appropriate Box: ☐ *Minor* ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐ *Separated* *Sex* ☐ *M* ☐ *F*

Patient's or Parents Employer _____ *Work Phone* _____

Business Address _____ *City* _____ *State* _____ *Zip* _____

Spouse or Parent's Name _____ *Spouses Employer* _____ *Occupation* _____ *Work Phone* _____

If Patient is a Student, Name of School/College _____ *City* _____ *State* _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ *Relationship* _____ *Phone* _____

Responsible Party

Name of person responsible for this account _____ *Relationship to patient* _____

Address _____ *Home Phone* _____

Social Security # _____ *Birthdate* _____

Employer _____ *Work Phone* _____

Is this person currently a patient in our office? ☐ *Yes* ☐ *No*

Insurance Information

Name of Insured _____ *Relationship to patient* _____

Birthdate _____ *Social Security #* _____ *Date Employed* _____

Name of Employer _____ *Work Phone* _____

Address of Employer _____ *City* _____ *State* _____ *Zip* _____

Insurance Company _____ *Group #* _____ *Union or local#* _____

Ins. Co. Address _____ *City* _____ *State* _____ *Zip* _____

How much is your deductible? _____ *How much have you used?* _____ *Max annual benefit* _____

DO YOU HAVE ADDITIONAL INSURANCE? ☐ ***Yes*** ☐ ***No*** ***IF YES COMPLETE THE FOLLOWING***

Name of Insured _____ *Relationship to patient* _____

Birthdate _____ *Social Security #* _____ *Date Employed* _____

Name of Employer _____ *Work Phone* _____

Address of Employer _____ *City* _____ *State* _____ *Zip* _____

Insurance Company _____ *Group #* _____ *Union or local#* _____

Ins. Co. Address _____ *City* _____ *State* _____ *Zip* _____

How much is your deductible? _____ *How much have you used?* _____ *Max annual benefit* _____

OVER PLEASE

Patient Medical History

Physician _____ Office Phone _____ Date of last exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Do you require antibotics Pre-medication?	☐	☐
4. Are you taking any medication(s) including non-prescription medicine?	☐	☐

If yes, what medication(s) are you taking? _____

_____

_____

_____

_____

	Yes	No
5. Do you use tobacco?	☐	☐
6. Do you use cocaine or other drugs?	☐	☐
7. Are you wearing contact lenses?	☐	☐

8. Are you allergic to or have you had any reaction to the following?	Yes	No
Metal/Nickel	☐	☐
Local Anesthetics (eg.novacaine)	☐	☐
Penicillin or other antibotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other-List _____		

9. Women Only:	Yes	No
a) Are you Pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐

10. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pain	☐	☐
Heart attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumaatic fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizers	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV infection	☐	☐	Sexually Transmitted Disease	☐	☐	Other	☐	☐
Thyroid problem	☐	☐	Stomach Troubles/ Ulcers	☐	☐			

11. What is your reason for your visit today? _____

Patient Dental History

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following Problems in your jaw?	☐	☐
a) Clicking?	☐	☐
b) Pain (joint, ear, side of face)?	☐	☐
c) Difficulty in opening or closing?	☐	☐
d) difficulty in chewing?	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9.Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extraction in the past?	☐	☐
12. Have you ever had any orthodontic work?	☐	☐
13. Have you ever had any prolonged bleeding following extractions?	☐	☐
14. Have you ever had instruction on the correct method of brushing youe teeth?	☐	☐
15. Have you ever had instruction on the care of your gums?	☐	☐
16. Date of last Dental Cleaning _____ X-rays _____		
17.Do you know someone who snores?	☐	☐

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answerd. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents; $12.00 service charge for late accounts. I also agree to be responsible for 100% of the collections costs and legal fees. I understand that the collection cost might add an additional 50% to my principal balance.

X _____

Signature of patient or parent if minor *Relationship*